BEFORE THE DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of ARM 37.85.212 pertaining to the resource based relative value scale (RBRVS)	))))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT

TO: All Interested Persons

1. On May 2, 2007, at 3:00 p.m., a public hearing will be held in the auditorium of the Department of Public Health and Human Services Building, 111 N. Sanders, Helena, Montana to consider the proposed amendment of the above-stated rule.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who need an alternative accessible format of this notice or provide reasonable accommodations at the public hearing site. If you need to request an accommodation, contact the department no later than 5:00 p.m. on April 23, 2007, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970; e-mail dphhslegal@mt.gov.

2. The rule as proposed to be amended provides as follows. Matter to be added is underlined. Matter to be deleted is interlined.

37.85.212 RESOURCE BASED RELATIVE VALUE SCALE (RBRVS) REIMBURSEMENT FOR SPECIFIED PROVIDER TYPES (1) For purposes of this rule, the following definitions apply:

(a) through (e) remain the same.

(f) "Resource based relative value scale (RBRVS)" means the most current version of the Medicare resource based relative value scale contained in the physicians' Medicare Physician Fee Schedule adopted by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services and published at ~~70~~ 71 Federal Register ~~70116 (November 21, 2005)~~ 69736 (December 1, 2006), effective January 1, ~~2006~~ 2007 which is adopted and incorporated by reference. A copy of the Medicare Physician Fee Schedule may be obtained from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. The RBRVS reflects RVUs for estimates of the actual effort and expense involved in providing different health care services.

(g) through (2)(s) remain the same.

(3) Except as set forth in ~~(8)~~ (7) through ~~(12)(a)(vi)~~ (11)(a)(vi), the fee for a covered service provided by any of the provider types specified in (2) through (2)(s) is determined by multiplying the RVUs determined in accordance with ~~(7)~~ (6) through

~~(7)(b)(iii)~~ (6)(a)(ii)(C) by the conversion factor, which is required to achieve the overall budget appropriation for ~~physician~~ provider services ~~in House Bill 2 of the 2005 legislative session (the General Appropriations Act of 2005)~~ made by the Montana Legislature in the most recent legislative session and then multiplying the product by a factor of one plus or minus the applicable policy adjustor as provided in (4) ~~or (5)~~, if any.

~~(4) On July 1, 2006, $324,500 total additional funds for state fiscal year 2007 will be applied to well child preventative visits.~~

~~(5)~~ (4) For state fiscal year ~~2007~~ 2008, policy adjustors will be used to accomplish the targeted funding allocations, which apply to family planning services, maternity services, and well child preventative visits as directed by the legislature. The department's list of services affected by policy adjustors through January 1, ~~2006~~ 2007 is adopted and incorporated by reference. The list is available from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

~~(6)~~ (5) The RVUs for most services are adopted from the resource based RBRVS. ~~For most services for which the RBRVS does not specify RVUs, the department sets those RVUs.~~

(6) For services for which the RBRVS does not specify RVUs, the department sets those RVUs as follows:

~~(7)~~ (a) The RVUs for a Medicaid covered service provided by any of the provider types specified in (2) are calculated as follows:

~~(a)~~ (i) if Medicare sets RVUs, the Medicare RVUs are applicable;

~~(b)~~ (ii) if Medicare does not set RVUs but Medicaid sets RVUs, the Medicaid RVUs are set in the following manner:

~~(i)~~ (A) convert the existing dollar value of a fee to an RVU value;

~~(ii)~~ (B) evaluate the RVU of similar services and assign an RVU value; or

~~(iii)~~ (C) convert the average by report dollar value of a fee to an RVU value.

~~(8)~~ (7) Except for physician administered drugs as provided in ARM 37.86.105(3), clinical, laboratory services and anesthesia services, if neither Medicare nor Medicaid sets RVUs, then reimbursement is by report.

(a) Through the by report methodology the department reimburses a percent of the provider's usual and customary charges for a procedure code where no fee has been assigned. The percentage is determined by dividing the previous state fiscal year's total Medicaid reimbursement for RBRVS provider covered services by the previous state fiscal year's total Medicaid billings.

(b) For state fiscal year ~~2007~~ 2008, the by report rate is ~~46%~~ 46% of the provider's usual and customary charges.

~~(9)~~ (8) For clinical laboratory services for which there is an established fee:

(a) the department pays the lower of the following for procedure codes with fees:

(i) the provider's usual and customary charges for the service; or

(ii) 60% of the Medicare fee schedule for physician offices and independent labs and hospitals functioning as independent labs; or

(iii) the established Medicaid fee.

(b) for clinical laboratory services for which there is no established fee, the department pays the lower of the following for procedure codes without fees:

(i) the provider's usual and customary charges for the service;

(ii) the rate established using the by report methodology; or

(A) for purposes of ~~(9)(b)~~ (8)(b) through ~~(9)(b)(iii)~~ (8)(b)(iii), the by report methodology means averaging 50 paid claims for the same code that have been submitted within a 12 month span and then multiplying the average by the amount specified in ~~(8)(b)~~ (7)(b).

(iii) the historical comparative value of the procedure as indicated by the reimbursement amount paid by Medicaid and other third party payors for the same procedure within the last 12 months.

~~(10)~~ (9) For anesthesia services the department pays the lower of the following for procedure codes with fees:

(a) the provider's usual and customary charges for the service;

(b) a fee determined by multiplying the anesthesia conversion factor by the sum of the applicable base and time units, and then multiplying the product by a factor of one plus or minus the applicable policy adjustor, if any;

(c) the department pays the lower of the following for procedure codes without fees:

(i) the provider's usual and customary charges for the services; or

(ii) the by report rate.

~~(11)~~ (10) For equipment and supplies:

(a) the department pays the lower of the following for durable medical equipment (DME) items with fees:

(i) the provider's invoice cost for the DME; or

(ii) the Medicaid fee schedule as provided in ARM 37.86.1807.

(b) the department pays the lower of the following for DME items without fees:

(i) the provider's invoice cost for the DME; or

(ii) the by report rate provided in ~~(8)(b)~~ (7)(b).

(c) except for the bundled items as provided in ~~(13)~~ (12), the department pays the lower of the following for supply items with fees:

(i) the provider's invoice cost for the supply item; or

(ii) the Medicaid fee schedule as provided in ARM 37.86.1807.

(d) except for bundled items as provided in ~~(13)~~ (12), the department pays the lower of the following for supply items without fees:

(i) the provider's invoice cost for the supply item; or

(ii) the by report rate provided in ~~(8)(b)~~ (7)(a).

~~(12)~~ (11) Subject to the provisions of ~~(12)(a)~~ (11)(a), when billed with a modifier, payment for procedures established under the provisions of ~~(7)~~ (6) is a percentage of the rate established for the procedures.

(a) The methodology to determine the specific percent for each modifier is as follows:

(i) The department obtains information from Medicare and other third party payors regarding the comparative value utilized for payment of procedures billed with modifiers.

(ii) The department establishes a specific percentage for each modifier based upon the purpose of the modifier, the comparative value of the modified service and the medical insurance industry trend of reimbursement for the modifier.

(iii) The department's list of the specific percents for the modifiers used by Medicaid as amended through January 1, 2005 is adopted and incorporated by reference. A copy of the list is available on request from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(iv) Notwithstanding any other provision, procedure code modifiers "80", "81", "82", and "AS", used by assistant surgeons shall be reimbursed at 16% of the department's fee schedule.

(v) Notwithstanding any other provision, procedure code modifier "62" used by cosurgeons shall be reimbursed at 62.5% of the department's fee schedule for each cosurgeon.

(vi) Notwithstanding any other provision, subsequent surgical procedures shall be reimbursed at 50% of the department's fee schedule.

~~(13)~~ (12) In applying the RBRVS methodology set forth in this rule, Medicaid reimburses in accordance with Medicare's policy on the bundling of services, as set forth in the physicians' Medicare Fee Schedule adopted by CMS and published in the Federal Register annually, whereby payment for certain services constitutes payment for certain other services which are considered to be included in those services.

~~(14)~~ (13) Providers must bill for services using the procedure codes and modifiers set forth, and according to the definitions contained in the Federal Health Care Administration's Common Procedure Coding System (HCPCS). Information regarding billing codes, modifiers, and HCPCS is available upon request from the Health Resources Division at the address previously stated in this rule.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

3. The Medicaid program provides medical assistance to qualified low income and disabled residents of Montana. The state of Montana and the federal government jointly fund the program. The Montana Medicaid program pays enrolled providers for services to eligible individuals. The purpose of this rule amendment is to update the Resource Based Relative Value Scale (RBRVS) fees paid to enrolled providers in accordance with the most recently published relative value units (RVUs) released by Centers for Medicare and Medicaid Services (CMS). This rule amendment is necessary to incorporate the updated relative value units (RVUs) published in the Federal Register in December 2006. The updated RVUs are effective for the Medicare program on January 1, 2007. The change in the Montana Medicaid fees is effective July 1, 2007.

Since August 1997 the Department of Public Health and Human Services (DPHHS) has used RBRVS-based fee schedules as the basis for paying almost all services provided by physicians, mid-level practitioners, therapists, and other individual practitioners. RBRVS was developed by the Medicare program and first implemented in 1992. It is now widely used by the Medicare plans, Workers' Compensation plan and private sector insurers. For DPHHS and these other payors, the only services not typically paid via RBRVS are anesthesia services,

clinical lab services, drugs provided in the office, durable medical equipment and supplies provided in the office, and a few miscellaneous items such as blood products.

Each procedure is identified by a number system, referred to as CPT code and Healthcare Common Procedure Coding System (HCPCS). The CPT and HCPCS code is assigned a relative value unit (RVU). The RVUs represent work, practice expense, and professional liability insurance. Annual updates to RVUs are based on recommendations of a committee of the American Medical Association (AMA) and the Specialty RVS Update Committee (RUC). Montana Medicaid incorporates these updates at the beginning of each state fiscal year. For each CPT and HCPCS code the RVUs are set at a national level and are adjusted to the Montana setting using Medicare's Geographic Practice Cost Index (GPCI) for Montana.

Payments are calculated by multiplying the combined costs (the RVU) by a conversion factor (CF), a monetary amount that is determined by each payor. Medicaid is a payor. Additionally, policy adjustors are applied for those services that receive either fewer or additional targeted funds such as obstetric care, well child screens, and family planning. Policy adjustors can be used to increase or decrease a level of payment.

The RBRVS calculation formula is RVU * CF * policy adjustor = reimbursement rate. For example, in SFY 2006 two commonly billed services in the physician related service program were 99213 (office/outpatient visit) and 59400 (obstetric care). The RBRVS calculation for these are:

59400 - global package for vaginal delivery
RVU = 40.948
CF = $32.81
Maternity policy adjustor = 1.25
40.948 x 32.81 x 1.25 = fee of $1679.38

99213 - level 3 office visit
RVU = 1.279
CF = $32.81
1.279 x 32.81 = fee of $41.96

The 60th Legislature (2007-2008) is in session on the date of publication of this proposed rule amendment. The conversion factor, the by report rate, and the fiscal impact of this rule amendment are estimated as of April 12, 2007. The final rule will reflect changes, if any, resulting from the final actions of the Legislature.

To date the 60th Legislature (2007-2008) has primarily focused on physician reimbursement. ARM 37.85.212 specifies the reimbursement methodology for many medical professional providers (therapists, mid-level practitioners, and podiatrists for example) in addition to physicians. The final impact of the rule change is dependent on the Legislature's appropriation. The proposed amendment to ARM 37.85.212

impacts approximately 84,000 Medicaid clients and 6000 providers.

4. The department intends to apply these rules effective July 1, 2007. In the event the rules are amended retroactively no negative impact is anticipated.

5. Interested persons may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210, no later than 5:00 p.m. on May 10, 2007. Data, views, or arguments may also be submitted by facsimile (406)444-1970 or by electronic mail via the Internet to dphhslegal@mt.gov. The department also maintains lists of persons interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of interest. For placement on the mailing list, please write the person at the address above.

6. The Office of Legal Affairs, Department of Public Health and Human Services has been designated to preside over and conduct the hearing.

/s/ Geralyn Driscoll
Rule Reviewer

/s/ Joan Miles
Director, Public Health and Human Services

Certified to the Secretary of State April 2, 2007.